UNICARE.

PERSONAL HEALTH STATEMENT OF DEPENDENT

Section I - To Be Completed by Policyholder

POLICY / PLAN NO. _____ BILLING GROUP NO. _____ BILLING SUBGROUP / UNIT NO. _____ CLASS _____

POLICYHOLDER (EMPLOYER) _____ CERT. NO. _____ DATE EMPLOYED _____

NAME OF EMPLOYEE _____ DATE OF BIRTH _____ SEX ☐M ☐F

EMPLOYEE'S HOME ADDRESS _____ LATE APPLICANT: ☐YES ☐NO

Section II - To Be Completed by Employee (The following statements by the employee relate to the dependent)

NAME OF DEPENDENT _____ RELATIONSHIP _____

DEPENDENT'S DATE OF BIRTH _____ SEX ☐M ☐F DEPENDENT'S SOCIAL SECURITY NO. _____

	ANSWER YES OR NO	IF ANY PART IS ANSWERED "YES" GIVE PARTICULARS AND DATES
1. DOES THE DEPENDENT HAVE ANY DISEASE OR AILMENT AT THE PRESENT TIME?		
2. IF THE ANSWER TO QUESTION NO. 1 IS YES, DOES THE DEPENDENT CONTEMPLATE OR HAS A PHYSICIAN RECOMMENDED AN OPERATION OR NAY MEDICAL TREATMENT FOR THIS CONDITION?		
3. DURING THE PAST FIVE YEARS HAS THE DEPENDENT		
A. HAD ANY DISEASE OF THE KIDNEYS?		
B. BEEN ADVISED THAT HE OR SHE HAS DIABETES? (IF YES, PROVIDE TWO READINGS AND MEDICATIONS).		
C. HAD ANY DISEASE OF THE HEART?		
D. BEEN ADVISED THAT HE OR SHE HAS ABNORMAL BLOOD PRESSURE? (IF YES, PROVIDE TWO READINGS AND MEDICATIONS).		
E. HAD ANY DISEASE OF THE STOMACH OR BOWEL?		
F. BEEN DIAGNOSED OR TREATED BY A MEMBER OF THE MEDICAL PROFESSION FOR ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) OR ANY AIDS RELATED CONDITION (ARC)?		
G. HAD ANY DISEASE OF THE LUNGS?		
H. HAD ANY DISEASE OF THE NEUROLOGICAL SYSTEM?		
I. HAD ANY DISEASE OF THE GENITAL OR URINARY TRACT?		
J. HAD ANY DISEASE OF THE MUSCULO-SKELETAL SYSTEM?		
K. HAD ADVICE, ATTENDANCE OR TREATMENT BY A PHYSICIAN, PRACTITIONER OR ANOTHER PERSON? (GIVE DATES AND REASON)		
L. HAD TREATMENT OR OBSERVATION IN A CLINIC, HOSPITAL OR RESIDENTIAL TREATMENT PROGRAM? (GIVE DATES AND REASON)		
4. A. HAS THE DEPENDENT EVER APPLIED FOR LIFE, HEALTH, OR ACCIDENT COVERAGE AND BEEN DECLINED, POSTPONED OR RESTRICTED, OR HAS A POLICY BEEN ISSUED AND AFTERWARDS CANCELLED?		
B. HAS THE DEPENDENT EVER RECEIVED INSURANCE BENEFITS OR COMPENSATION OF ANY KIND FOR ILLNESS OR INJURY?		

5. WHEN AND FOR WHAT DID THE DEPENDENT LAST CONSULT A PHYSICIAN? GIVE DATE, NAME AND ADDRESS OF PHYSICIAN OR PRACTITIONER, AND NATURE OF INJURY OR ILLNESS.

6. WHAT IS DEPENDENT'S HEIGHT? _____ FEET _____ INCHES, WEIGHT _____ POUNDS? 7. IS DEPENDENT PREGNANT? ☐YES ☐NO

8. APPROVAL REQUESTED FOR FOLLOWING COVERAGES

☐MEDICAL ☐DEPENDENT LIFE $ _____ ☐DRUGS ☐EXEC. SUPP. ☐VISION ☐OTHER (specify) _____

TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE FOREGOING STATEMENTS AND ANSWERS, EACH OF WHICH I HAVE MADE AND READ, ARE COMPLETE AND TRUE, AND ARE CORRECTLY AND FULLY RECORDED. I UNDERSTAND THAT ANY MISREPRESENTATION CONTAINED HEREIN RELIED ON BY THE COMPANY MAY BE USED TO REDUCE OR DENY A CLAIM OR VOID THE CONTRACT WITHIN THE CONTESTABLE PERIOD IF SUCH MISREPRESENTATION MATERIALLY AFFECTS THE ACCEPTANCE OF THE RISK. I HEREBY DECLARE THAT A DUPLICATE COPY OF THIS INSTRUMENT CONTAINING THE ABOVE STATEMENTS OR ANSWERS TOGETHER WITH ANY EXPLANATIONS THERE TO HAS BEEN FURNISHED TO ME BY THE INSURANCE COMPANY.

WITNESS _____ ▶ SIGNATURE OF EMPLOYEE _____ DATE _____

PLEASE READ AND SIGN THE REVERSE SIDE OF THIS FORM

Section III - For UNICARE Use

Decision: ☐ Approved ☐ Declined ☐ Day 1 Plan ☐ Date Eligible Plan Date of Approval ____/____/____ Reviewed by: _____ Regional Service Center _____

If Declined, Reason: _____

White - UNICARE Copy *Canary - Regional Service Center Copy* *Pink - Policyholder Copy*

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